

# WORKERS COMPENSATION EMPLOYER'S FIRST REPORT OF INJURY OR ILLNESS

OSHA CASE/FILE #

Form 122

## CONTAINS ALL ITEMS REQUIRED BY OSHA FORM 101

GENERAL	EMPLOYER (Name & address Incl. Zip)		CARRIER/ADMINISTRATOR CLAIM NUMBER		REPORT PURPOSE CODE
	STATE OF UTAH DIV OF RISK MNGT 5120 STATE OFFICE BLDG  SALT LAKE CITY UT 84114		JURISDICTION	JURISDICTION CLAIM NUMBER	
			INSURED REPORT NUMBER		
	SIC CODE 9441		EMPLOYER FEIN 876000545		EMPLOYER'S LOCATION ADDRESS (IF DIFFERENT) DEPT OF HEALTH P O BOX 141011 SALT LAKE CITY UT 84114-1011
			LOCATION # 17		PHONE # 538-6130
CARRIER	CARRIER (NAME, ADDRESS & PHONE NO.) Workers Compensation Fund of Utah P.O. Box 57929 Salt Lake City, UT 84157-0929 Telephone: (801) 288-8010		POLICY PERIOD TO		CLAIMS ADMINISTRATOR (NAME, ADDRESS & PHONE NO.) Workers Compensation Fund P.O. Box 57929 Salt Lake City UT 84157-0929
	CHECK IF APPROPRIATE [ ] SELF INSURANCE				
	CARRIER FEIN	POLICY/SELF INSURED NUMBER 1758386			ADMINISTRATOR FEIN
	AGENT NAME & CODE NUMBER				
EMPLOYEE	NAME (LAST, FIRST, MIDDLE)		DATE OF BIRTH	SOCIAL SECURITY NUMBER	DATE HIRED
	ADDRESS (INCL. ZIP)		GENDER	MARITAL STATUS	STATE OF HIRE UT
	HOME PHONE:		# OF DEPENDENTS		OCCUPATION/JOB TITLE
	WORK PHONE:				EMPLOYMENT STATUS
	RATE: PER:		FULL PAY FOR DAY IF INJURY?		NCCI CLASS CODE
	NUMBER OF DAYS WORKED/WEEK:		DID SALARY CONTINUE?		
OCCURRENCE	LAST WORK DATE:			DATE EMPLOYER NOTIFIED	
	TIME EMPLOYEE BEGAN WORK:				
	DATE OF INJURY:			DATE DISABILITY BEGAN	
	TIME OF OCCURRENCE:				
	CONTACT NAME/PHONE NUMBER		TYPE OF INJURY/ILLNESS		
	DID INJURY/ILLNESS EXPOSURE OCCUR ON EMPLOYER'S PREMISES?		PART OF BODY AFFECTED CODE		
	DEPARTMENT OR LOCATION WHERE ACCIDENT OR ILLNESS EXPOSURE OCCURRED		ALL EQUIPMENT, MATERIALS, OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED		
	SPECIFIC ACTIVITY EMPLOYEE WAS ENGAGED IN WHEN THE ACCIDENT OR ILLNESS EXPOSURE OCCURRED		WORK PROCESS THE EMPLOYEE WAS ENGAGED IN WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED		
HOW INJURY OR ILLNESS/ABNORMAL HEALTH CONDITION OCCURRED, DESCRIBE THE SEQUENCE OF EVENTS AND INCLUDE ANY OBJECTS OR SUBSTANCES THAT DIRECTLY INJURED THE EMPLOYEE OR MADE THE EMPLOYEE ILL.			CAUSE OF INJURY CODE		
DATE RETURN(ED) TO WORK		IF FATAL, GIVE DATE OF DEATH		WERE SAFEGUARDS OR SAFETY EQUIPMENT PROVIDED? WERE THEY USED?	
TREAT	PHYSICIAN/HEALTH CARE PROVIDER (NAME & ADDRESS)		HOSPITAL (NAME & ADDRESS)		INITIAL TREATMENT
OTHER	WITNESS (NAME & PHONE)				
	DATE ADMINISTRATOR NOTIFIED	DATE PREPARED	PREPARER'S NAME & TITLE EILEENE SIMON HUMAN RESOURCE TECHNICIAN II PHONE NUMBER: 538-6626 EMAIL ADDRESS: esimon@doh.state.ut.us		
WORKERS COMPENSATION FUND INFORMATION (THIS INFORMATION IS NECESSARY TO PROCESS CLAIM)					
OFFICER/PARTNER N		DID INJURY HAPPEN DURING PERFORMANCE OF REGULAR DUTIES? Y		POLICY DEPT. CODE	
ACCIDENT CAUSE CODE		IF THE ACCIDENT WAS CAUSED BY ANY PERSON OR COMPANY BESIDES THE EMPLOYEE, A CO-EMPLOYEE, OR THE EMPLOYER, PLEASE IDENTIFY:			
WAS ACCIDENT CAUSED BY FAILURE OF MACHINE OR PRODUCT? IF YES, EXPLAIN:		HAS EMPLOYEE INJURED THIS PART OF BODY BEFORE?		DO YOU DOUBT THE VALIDITY OF THIS CLAIM? NO IF SO, PLEASE EXPLAIN:	